STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Survey dates : July 15, 16, 17, 18, & 19, 2013 Facility number: 000007 Provider number: 155019 AIM number: 100275040 Survey team: Cheryl Mabry, RN-TC Kimberly Perigo, RN Diana McDonald, RN Melissa Gillis, RN Denise Schwandner, RN Census bed type: SNF: 15 SNF/NF: 165 Total: 180 Census payor type: Medicare: 20 Medicaid: 122 Other: 38 Total: 180 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on July 30, 2013, by	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Jodi Meyer, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to obtain weekly blood pressures as indicated in the resident's written plan of care for 1 of 40 residents reviewed for care plan implementation. (Resident #131) Findings include: Resident #131's clinical records were reviewed on July 18, 2013 at 10:11 a.m. Resident #131's diagnoses included, but were not limited to dementia, bipolar disorder with psychosis, chronic pain, depression, hypertension, and chronic renal insufficiency. Resident #131's care plan dated January 21, 2013 indicated, "...Resident's blood pressure will stay within normal limits as evidenced by weekly monitoring...Monitor B/P [blood pressure] weekly. Report abnormal B/P to M.D.[Medical Doctor]...."	F000282	It is the policy of Garden Villa to provide services by qualified persons in accordance with each resident's written plan of care. Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #131 has had the care plan updated to reflect current care needs and monitoring. Previously this order had been discontinued but was not removed from the plan of care, this has been corrected. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected. All care plans have been reviewed to ensure that current needs are on the plan and non-needed items removed. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Care plans will be reviewed with each update to the staff assignment sheets and upon	08/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interview with LPN #13 on July 19, 2013 at 3:25 p.m., indicated monthly blood pressures are recorded on the monthly vitals form for residents not on blood pressure medication. For residents on weekly blood pressure monitoring, the blood pressure is documented on the Medication Administration Record. Vital Signs and weight record indicated Resident #131's blood pressure was recorded monthly April 2013 through July 2013. Medication Administration Records dated April 2013 through July 2013 lacked documentation to indicated Resident #131's blood pressure was monitored weekly as indicated by the care plan. Continued interview on July 19, 2013 with LPN #13 indicated Resident #131's blood pressure was not monitored weekly, but done monthly. 3.1-35(g)(2)		any change in condition. At the least, will be reviewed monthly during change over to ensure that care plan reflects the current resident needs. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? Weekly audits of the care plans will be conducted by nursing administration or designee to verify all interventions reflect the resident current condition. 100% of all resident new orders will be audited. This audit will be conducted weekly for 3 months and results reviewed in Quality Assurance. At 3 months, Quality Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. V. August 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to accurately post the daily resident census on the facility's posted staffing data record for 3 of 5 days of the	F000356	It is the policy of Garden Villa to accurately post nurse staffing information as required.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. I. What corrective	08/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	survey. Findings include: Observation on July 15, 2013 at 10:10 a.m., the posted staffing data record located on the receptionist's desk indicated a total resident census of 176. Observation on July 16, 2013 at 8:30 a.m., the posted staffing data record located on the receptionist's desk indicated a total resident census of 181. Observation on July 17, 2013 at 9:00 a.m., the posted staffing data record located on the receptionist's desk indicated a total resident census of 176. Review of the facility ' s resident census, provided by the Administrator on July 17, 2013 at 2:30 p.m., indicated the July 15, 2013 resident census at 180; the July 16, 2013 resident census at 183; and the July 17, 2013 resident census at 181. Interview on July 17, 2013 at 10:45 a.m.; the Director of Nursing indicated the facility census is posted daily with the posted staffing data record at the front receptionist ' s desk.		action(s) will be accomplished for those residents found to have been affected by the deficient practice?The posted census has been corrected. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?Census will be verified with the Admissions coordinator to ensure correct postings. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Careful review of daily resident census posting will be conducted with the staffing and Admissions coordinators to ensure accuracy. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Administration will daily audit the staffing data record prior to posting. Audit results will be presented in Quality Assurance monthly times 3 months.At 3 months, Quality Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. V. August 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure working hot water for 1 of 1 handwashing sinks, failed to ensure 1 of 1 walk in freezer temperatures were maintained at zero degrees or below and failed to ensure staff washed their hands between residents during meal service as indicated by facility policy. Findings include: 1. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated no hot water was available at the kitchen handwashing sink. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated no hot water was available at the kitchen handwashing sink. Dietary staff in the kitchen were observed to be washing their hands at the observed handwashing sink.	F000371	It is the policy of Garden Villa to store , prepare, distribute, and serve food under sanitary conditions.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Mixing valve was replaced on the sink on the day observed. Sink/hot water available and functioning as required. b. Freezer was assessed to ensure good working condition by Lower's Heating and Cooling. In addition to ensuring the current freezer is in good working condition a new freezer was ordered to be used in addition to the current freezer to reduce stacked products and improve air flow to maintain zero degrees. Until the new freezer is in place the frozen food shipments have been changed to 2 a week instead of 1 large order. Therefore reducing the freezer capacity to half. c. Hand washing re-education conducted with all direct care staff and dietary. II. How other	08/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Correct Method to Wash Hands" non-dated policy. Review of the policy indicated, "Use a designated sink for handwashing. Wet hands and apply soap. Rub hands vigorously making sure to wash palms, back of hands, between fingers and forearms for at least 20 seconds in water of at least 100 F [degrees Fahrenheit]..." 2. Observation on July 15, 2013 at 10:10 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit. Ice cream stored just inside and to the right of the open side of the walk in freezer was observed to be soft. The walk in freezer was observed to be full of meats. The Dietary Chef verified the ice cream to be soft and then discarded the ice cream into the trash. Observation on July 16, 2013 at 8:00 a.m.; with the Dietary Chef present, indicated the walk in freezer thermometer measured the inside temperature at 16 degrees Fahrenheit.		residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? a. All residents have the potential to be affected. Alternative sink has been identified for hand washing if hot water not available and staff have been educated. Immediate attention for repair will be obtained as was done in this circumstance. b. Freezer temperatures are being monitored twice daily to ensure they stay below zero degrees. Care is being taken when staff need to be in the freezer frequently to reduce the door from being open long and reducing the overall temperature. Second freezer will be in and ready for use in September. Two deliveries a week are now being made instead of one large order to reduce the freezer capacity load thus increasing air flow and maintaining the temperature at zero or below. c. Hand washing re-education conducted with all direct care staff and dietary, currently, upon hire and at least annually. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? a. Alternative sink has been identified for hand washing if hot water not available and staff have been educated on it's use. Immediate attention for repair will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On July 15, 2013 at 10:55 a.m.; the Dietary Chef provided a copy of the facility's "Critical Temperatures for Food Service" non-dated policy. Review of the policy indicated, "The following temperature guidelines, based on the federal Food and Drug Administration's 2009 Food Code ... Strictly maintaining these temperatures is particularly important when dealing with potentially hazardous foods. ... Frozen foods 0 F [zero degrees Fahrenheit] or below. 3. Observation of RN #1 on July 15, 2013 at 12:09 p.m.; indicated lack of handwashing or use of sanitizing hand gel between assisting two residents during lunch. RN #1 was observed cutting food for Resident #16 and then moved the chair, in which the resident was seated. RN #1 then assisted Resident #10 with eating lunch without washing hands or using sanitizing gel. Review of non-dated Handwashing Procedures provided by the Dietary Chef on July 19, 2013 at 2:45 p.m. indicated, "When to Wash Hands ... between activities." 3.1-21(i)(2) 3.1-21(i)(3)		be obtained as was done in this circumstance. b. Freezer temperatures are being monitored twice daily to ensure they stay below zero degrees. Care is being taken when staff need to be in the freezer frequently to reduce the door from being open long and reducing the overall temperature. Second freezer will be in and ready for use September. Two deliveries a week are now being made instead of one large order to reduce the freezer capacity load thus increasing air flow and maintaining the temperature at zero or below. c. Hand washing re-education conducted with all direct care staff and dietary, currently, upon hire and at least annually. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? a.. All dietary staff have been educated on the requirements of hand washing and water temperatures. If at anytime no hot water is available the staff must report immediately for repair and sink taken out of service. Water temps. will be audited twice weekly for 3 months to ensure hot water requirements. Audit results will be reviewed in Quality Assurance committee monthly . At 3 months, Quality Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. b. Freezer temperatures are being monitored twice daily to ensure they stay below zero degrees. Care is being taken when staff need to be in the freezer frequently to reduce the door from being open long and reducing the overall temperature. Second freezer will be in and ready for use September. Two deliveries a week are now being made instead of one large order to reduce the freezer capacity load thus increasing air flow and maintaining the temperature at zero or below. At 3 months, Quality Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. c. Hand washing audits will be conducted twice weekly on each unit for 3 months. At 3 months, Quality Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. V. August 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure staff documented the date multi vial medications were opened	F000431	It is the policy of Garden Villa to label drugs in accordance with current accepted professional principles and discard expired medications per manufacturer	08/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and failed to remove outdated medications for 5 of 10 medication carts reviewed. Findings include: 1. Observation on July 18, 2013 at 2:15 p.m., with RN # 4 present, indicated a bottle of over the counter medication (Milk of Magnesia) in the 6 unit medication cart #1 was identified to be outdated. The bottle of medication was outdated on May 2013. Observation on July 18, 2013 at 2:15 p.m., with RN # 4 present, indicated a bottle of eye drops on unit 6 medication cart #1 was identified to be outdated. The eye medication bottle was opened December 12, 2012. 2. Observation on July 18, 2013 at 3:00 p.m., with LPN # 6 present, indicated an opened insulin bottle in the 3 South medication cart # 2 did not have the open date documented on the bottle nor on the box.		guidelines.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?All medication out of date has been discarded. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?All residents have the potential to be affected. All medication carts have been audited for expired or non-labeled drugs. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur?Weekly audits will be conducted on all medication carts to ensure proper labeling and that no outdated medications are in use. Medication audits will be conducted and results presented in Quality Assurance Committee monthly. Audits will be done weekly for 3 months and then reviewed for scheduled change. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur? Medication audits will be conducted and results presented in Quality Assurance Committee monthly. Audits will be done weekly for 3 months and then reviewed for scheduled change.At 3 months, Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Observation on July 18, 2013 at 3:00 p.m., with LPN # 6 present, indicated a second opened insulin bottle in the 3 south medication cart # 2 was identified not to be in a box. There was no labeling on the bottle to indicate what resident the insulin belonged to. There was no documented open date on the insulin bottle. LPN #6 asked a resident on the 3 south unit whether he took that particular insulin or not. The asked resident indicated he did and LPN #6 stated, "I thought so. It's his." 3. Observation on July 18, 2013 at 3:00 p.m., with LPN # 6 present, indicated an opened insulin bottle in the 3 south medication cart # 3 was identified to be outdated. The insulin bottle was opened May 1, 2013. Observation on July 18, 2013 at 3:00 p.m., with LPN #6 present, indicated a second opened insulin bottle in the 3 south medication cart #3 was identified to be outdated. The insulin bottle was opened May 31, 2013. 4. Observation on July 18, 2013 at 3:30 p.m., with LPN # 14 present, indicated an opened insulin bottle in the 2 unit medication cart # 4 was		Assurance will review previous audit results to determine if the audits can be reduced to monthly. Quality Assurance will be looking for at least 95% compliant to reduce to monthly. If not meeting the benchmark weekly audits will continue. V. August 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	identified to be outdated. The insulin bottle was opened June 8, 2013. Continued interview with LPN #14, in regard to unit 2 medication cart #3, indicated insulin expires 30 days after the insulin bottle is opened. 5. Observation on July 19, 2013 at 10:00 a.m., with LPN # 7 present, indicated an opened over the counter bottle (Milk of Magnesia) in the 3 north medication cart # 5 was identified to be outdated. The medication was outdated March, 2013. NovoLog insulin Manufacturer's Guidelines indicated, "...Novolog in use: Vials: Keep in the refrigerator...Throw away an opened vial after 28 days of use, even if there is insulin left in the vial." Review on July 19, 2013 at 9:35 a.m., of "Vials and Ampules of Injectable Medications" policy (non-dated) provided by the Director of Nursing indicated: "Vials and ampules of injectable medications are used in accordance with the manufacturer's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	recommendations or the provider pharmacy's directions for storage, use, and disposal. Procedures: A. Vials and ampules sent from the provider pharmacy in a box or container with the label on the outside are kept in that box or container. B. The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). ... F. Medication in multidose vials may be used (until the manufacturer's expiration date/for the length of time allowed by state law/according to facility policy for thirty days) if inspection reveals no problems during that time." 3.1-25 (o)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure residents' call light systems were working appropriately for 2 of 40 residents reviewed for working call light. (Resident #71 and #28) Findings include: 1. Resident #71's clinical record was reviewed on July 17, 2013 at 10:30 a.m. The current MDS (Minimum Data Set Assessment) dated May 4, 2013, indicated a BIMS (brief interview for mental status) score of 10, which indicated the resident was interviewable. July 15, 2013 at 11:00 a.m., during resident interview, Resident #71 was asked to push her call light. Resident #71 was observed to push the call light. The hall light indicator	F000463	It is the policy of Garden Villa to have resident call systems that communicate to staff.Garden Villa submits the following action as evidence of its commitment to compliance with regulatory requirements. I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #71 and resident #28 are roommates and share the same call light system. The system was functioning at the call light panel indicating what room needed assistance and the alarm was audibly sounding. The maintenance department determined the cause of the problem to be the bathroom switch which had not been completely re-set after it had been answered. This switch was replaced, for easy resetting. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected. All call lights have been monitored for proper working function. All lights are functioning. On-going preventative maintenance was	08/18/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	which alerts on unit staff the resident requested assistance, located outside and above the resident's room door did not light up. CNA #10 was informed about the call light not working correctly and she did tell maintenance about this at that time. Within 5 minutes of maintenance being notified of the non-working call light, maintenance did come into Resident #71's room and fixed the call light. Continued observation on July 15, 2013; indicated that there were no staff at the call light panel. Direct care staff were observed to be on the resident unit hall. During observation of Resident #71 on July 18, 2013 at 9:25 a.m., the ADON entered and checked the call light and it did not light up on the outside wall. 2. Resident #28's clinical record was reviewed on July 18, 2013 at 10:00 a.m. The current MDS (Minimum Data Set Assessment) dated May 3, 2013,		being done on a monthly basis but this has been changed to weekly. All lights, every room. Protocol for a broken light is to notify maintenance for immediate attention. This was done each time a light was identified, however a memo on call light maintenance protocol is out for all staff as a reference and re-education. III. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? Weekly preventative maintenance on all call lights is being done to ensure proper function. Memo is out for all staff on call light maintenance protocol as a reference. IV. How corrective action(s) will be monitored to ensure the deficient practice will not recur?Weekly preventative maintenance on all call lights is being done to ensure proper function. Preventative maintenance will be reviewed in Quality Assurance committee monthly and reviewed for schedule change. V. August 18, 2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was interviewable. Observation of Resident #28 on July 17, 2013 at 9:30 a.m.; indicated the call light was not working. Resident #28 was observed to push the call light and the hallway light did not turn on. It was reported to CNA #11, Resident #28's call light was not working appropriately. CNA #11 contacted Maintenance at that time and there was no observation of maintenance fixing the light. Interview on July 19, 2013 at 2:30 p.m., with Maintenance Supervisor, indicated they do routine random call light checks monthly on 4 to 5 rooms on each unit. They also do yearly room checkups. The Maintenance Supervisor provided a copy of Material and Labor Records. The forms indicated dated July 01, 2013, "Unit 400. Room 18. Call light needs to be replaced Service Performed: Get new call light button. Replaced call button." and July 18, 2013, "Unit 1. Room 107A. Call light bulb outside room without lighting up." Service Performed: Checked light bulb, it was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	07/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	good. Had to reset bathroom switch. Everything is fine." The Maintenance Supervisor indicated that is the only call that came in this week for call lights. 3.1-19(u)(1)			